Testifies before House Veterans Affairs Committee about His Legislation to Protect Elderly Veterans

September 29, 2010

Washington, D.C. – Congressman Joe Sestak (PA-07) was proud to appear today before the House Veterans' Affairs Health Subcommittee to give testimony on his bill, HR 3843, the Transparency for America's Heroes Act. This legislation directs the Secretary of Veterans Affairs to make available on the Department of Veterans Affairs (VA) website inspection reports that provide information about the quality of care at VA facilities. This would include redacted records and documents -- but not personal identifying information -- created by the VA as part of a medical quality-assurance program. The bill would also require the Secretary to ensure that any such records created during the two-year period before the enactment of this Act are also made available in the same manner.

"I have enormous respect for the VA's dedicated healthcare professionals. They have arguably the most difficult jobs in healthcare today. Their patients are very often frustrated by the bureaucratic nature of the VA and since the mid 1970s they have been forced to operate without the resources they need and deserve. The American people are in their debt. I am proud that since 2007 Congress is finally providing those hardworking professionals the ways and means to care for our Veterans—but more needs to be done. I am convinced, as a former Admiral, that there is a need for a cultural and procedural sea-change in the way the VA medical system operates -- and that the best way to ensure quality care in the VA is through stringent oversight and transparency," said the Congressman. "There must be full accountability for the care our Veterans receive and our Veterans, their families and the American public as a whole deserve to know that appropriate standards are being met."

Congressman Sestak introduced this legislation last fall after an inspection report by the Long Term Care Institute revealed that elderly Veterans were being subjected to substandard care in the Community Living Center at the Philadelphia VA Medical Center. In one case, a patient was left unattended for so long that live maggots were found falling out of a foot wound. Because the report was conducted under the VA's quality-assurance authority, ordinarily this report would have never been made available to the public. Its findings were only released because a VA official did not follow the ordinary protocol.

"If there are any other instances of inadequate VA care, they should be revealed immediately along with confirmation that appropriate corrective actions have been taken. My legislation would accomplish this, without releasing sensitive information which could be used to identify patients and healthcare professionals. I also look forward to the day when the VA and the Department of Defense have fully integrated their medical record keeping procedures such that discharged Veterans are no longer subjected to months of delay in seeing their benefits decided and that those decisions are based upon a comprehensive review of that Veteran's full and complete medical history," concluded Sestak.

Congressman Joe Sestak's Full Remarks:

Chairman Michaud, Ranking Member Brown, and distinguished members of the subcommittee, to begin, I would like to acknowledge the very hard work of this committee and our colleagues of both parties in the 110th and 111th Congresses who have provided the Department of Veterans Affairs unprecedented ways and means to care for our Veterans and their families. Though the VA had been severely underfunded for too long, congressional efforts since 2007 now afford our Veterans of three generations access to the best care ever afforded those who go into harms way on our behalf.

However, with those additional resources the VA has the responsibility to Congress, the American public, and most especially our Veterans to see that it operates to the highest possible standards of care. In support of that goal it is an honor to appear before you today to discuss my bill, H.R. 3843, the Transparency for America's Heroes Act. This legislation directs the Secretary of Veterans Affairs to make available on the Department of Veterans Affairs (VA) website redacted records and documents -- but not personal identifying information -- created by the VA as part of a medical quality-assurance program. It would also require the Secretary to ensure that any such records created during the two-year period before the enactment of this Act are also made available in the same manner.

I authored this bill because I have grown increasingly troubled by reports that give rise to concern of a lingering lack of consistent care and accountability within the VA. I must be very clear that I have the highest regard for the thousands of dedicated professionals of the VA – many of whom have spent their entire careers in service to our Veterans. However, for the past twenty four months there have been too many revelations of substandard care for Veterans. Congress and the American public have been belatedly informed of prostate cancer victims who received insufficient treatment, the possible exposure of more than 1,800 Veterans to serious diseases, including Hepatitis and HIV, while undergoing routine dental procedures, deficiencies in thoracic care and last September we learned -- only after a Freedom of Information Act request was filed -- that some elderly Veterans were being subjected to substandard, potentially neglectful care in the Philadelphia Community Living Center at the Philadelphia VA Medical Center.

The nursing home, according to the Long Term Care Institute's report, "failed to provide a sanitary and safe environment for their residents…(and) there was a significant failure to promote and protect their residents' rights to autonomy and to be treated with respect and dignity." Some of the examples cited shock the conscience. For example, one patient with an open foot wound was left unattended for so long that maggots were found falling out of the wound. Additionally, the floor was found to be covered with dried blood and feeding tubes. Another diabetic patient complained of chronic failure on the staff's part to administer his insulin shots on schedule.

After hearing these reports, it came to my attention that there were two other recent inspections, one by the Inspector General of the VA and one by the Joint Commission on Accreditation of Health Care Organizations, both of which concluded that the facility met quality standards based on the metrics used. However, it took this separate, external investigation by the Long Term Care Institute -- using a different set of inspection criteria-- to identify the serious problems at the facility under its old leadership.

What concerns me is the two VA-conducted reviews failed to discover these deficiencies, and that a Freedom of Information Act (FOIA) request was required to bring this latest revelation of poor care to light. In fact, the report should not have even been released after the FOIA petition was filed under current law because the third-party inspection was conducted under the VA's quality-assurance authority. In this case, the report was inadvertently leaked by a VA official who did not follow the normal protocol. This leads me to believe that there may be numerous other cases of deficient care which will never see the light of day because the inspections in question, like the one conducted by the Long Term Care Institute, were conducted under the VA quality-assurance authority.

Under current law, records and documents created by the VA as part of a designated quality-assurance program are confidential and privileged, and as a result cannot be disclosed to any person or entity except when specifically authorized by statute. The stated rationale for this practice is, according to the VA, to “create a proactive culture of quality improvement allowing for early identification and resolution of quality issues.” The VA also states that “elimination of protected document status for quality management activity documents would possibly have a chilling effect on the level of objectivity reflected within these improvement activities.”

As a former Admiral who led men and women into battle, I disagree with this assessment. I am convinced there is a need for a cultural and procedural sea-change in the way the VA medical system operates -- and that the best way to ensure quality care in the VA is through stringent oversight. This entails vigilance on the part of both Congress and the general public. If there are any other instances of inadequate VA care, they should be revealed immediately along with confirmation that appropriate corrective actions have been taken. My bill would accomplish this, without releasing sensitive information which could be used to identify patients and healthcare professionals.

If we fail to ensure this kind of accountability, the goals of the current administration and the hard work of the 110th and 111th Congress, to finally provide our Veterans the care and resources they have been denied for so long, will be compromised.

At issue is the very credibility of one of our nation’s most important and visible health care providers and that of our government itself. I am reminded of the long-term consequences of government’s failure for over two decades -- both in the Executive Branch and Congress -- to treat Veterans and their families in a responsible and accountable way. As our troops continue to return from Iraq and Afghanistan, we can, and must, do better.

Thank you, Mr. Chairman.

Born and raised in Delaware County, former 3-star Admiral Joe Sestak served in the Navy for 31 years and now serves as the Representative from the 7th District of Pennsylvania. He led a series of operational commands at sea, including Commander of an aircraft carrier battle group of 30 U.S. and allied ships with over 15,000 sailors and 100 aircraft that conducted operations in Afghanistan and Iraq. After 9/11, Joe was the first Director of "Deep Blue," the Navy's anti-terrorism unit that established strategic and operations policies for the "Global War on Terrorism." He served as President Clinton's Director for Defense Policy at the National Security Council in the White House, and holds a Ph.D. in Political Economy and Government from Harvard University. According to the office of the House Historian, Joe is the highest-ranking former military officer ever elected to the U.S. Congress.

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